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F 000	INITIAL COMMENTS The following citations represent the findings of the complaint survey for complaints #64029 and #65608. A revised 2567 was sent to the facility on 5/20/13.	F 000		
F 159 SS=F	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.	F 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 159	Continued From page 1 The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: The facility census was 28 residents with 22 residents reviewed for management of personal funds. Based on interview and record review the facility failed to have a system that utilized acceptable and accurate principles of accounting for residents with a personal funds account. Findings included: - On 5/8/13 observation of the resident trust account records revealed the following account balances: Resident #4's checking account balance was overdrawn $101.13 with $70.26 in the savings account. Resident #5's checking account balance was overdrawn $31.00 with a balance of $160.21 in the savings account.	F 159		

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F 159	Continued From page 2 Resident #6's checking account balance was overdrawn $110.00. Resident #7's checking account balance was overdrawn $160.00. Resident #8's checking account balance was overdrawn $10.00. Resident #9's checking account balance was overdrawn $180.00. Resident #10's checking account balance was overdrawn $70.53 with a balance of $200.03 in the savings account. On 5-8-13 at 11:39 a.m. an interview with Administrative staff A revealed he/she had taken over the resident trust account in January 2013. Staff A revealed the account had not been correctly balanced since that time. Staff A confirmed that all residents that had a trust were in one pooled account. Staff A revealed he/she worked with the bank to reconcile the checking and savings account however the account never balanced correctly. Staff A confirmed the facility had failed to send out quarterly statements to notify the residents or the resident responsible party of the balance in each resident trust account. Staff A confirmed the residents with an overdrawn balance had used the money of other residents including Medicaid-funded residents whose money was deposited in the pooled trust account to cover the overdraft amount. Staff A revealed the resident account balance was not checked prior to staff allowing the residents to withdrawal money for personal use. Staff A	F 159		

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F 159	Continued From page 3 revealed he/she would record the withdrawals when he/she had time. Administrative staff A revealed he/she needed to send out an individual letter to all the residents and responsible party to notify them of the current balance in each resident's account and collect money from those resident with negative balances in the trust account. The facility failed to provide a policy in regard to the resident trust account procedures as requested on 5/9/13. The facility failed to have a system that included providing quarterly statements to the residents with a resident trust account and failed to have a system that maintained an accurate accounting of the resident trust account.	F 159		
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: The facility census totaled 28 residents with 10 reviewed for conveyance of personal funds. Based on interview and record review the facility failed to convey the funds of 2 of 10 sampled residents within 30 days of the resident's death. (#11,#12)	F 160		

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Findings included:

- Review of resident #11's trust account records revealed the resident died on 3/24/13. The facility records revealed a conveyance of $40.00 was paid to the resident's family on 5/8/13.

On 5/9/13 at 11:39 a.m. an interview with Administrative staff A revealed the facility had conveyed the funds of all residents who had a resident trust to the family or the state recovery office within 30 days of the resident's death.

Review of the facility's account practices for the resident trust checking and savings account revealed Staff A was unable to provide a copy of the activity on the account for resident #11 prior to the resident's death.

The facility failed to provide a policy for conveyance of resident funds as requested on 5/9/13 and 5/13/13.

The facility failed to convey the balance of the resident #11's trust account within 30 days of the residents death.

- Review of facility resident trust account records for resident #12 revealed the date of death on 1/16/13. The facility records revealed a total conveyance of $327.87 was paid to the resident's family on 2/27/13.

On 5/9/13 interview with Administrative staff A revealed the facility had conveyed the funds of all resident who had a resident trust to the family or the state recovery office within 30 days of the resident's death.

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F 160	Continued From page 5 Review of the facility's account practices for the resident trust checking and savings account revealed Staff A was unable to provide a copy of the activity on the account for resident #12 as requested on 5/9/13 and 5/13/13. The facility failed to provide a policy for conveyance of resident funds as requested on 5/8/13 and 5/13/13. The facility failed to convey the balance of the resident #12's trust account within 30 days of the residents death.	F 160		
F 225 SS=F	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		

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F 225	Continued From page 6 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility census totaled 28 residents with 3 residents included in the sample. Based on observation, interview and record review. The facility failed to thoroughly investigate and report alleged abuse to the state mandated agency for 1 of 3 sampled residents. (#1) Findings included: - Review of resident #1's face sheet revealed an admission date of 4/23/13. Review of resident #1's admission MDS (minimum data set) dated 4/30/13 revealed a BIMS (brief interview for mental status) score of 15 (cognitively intact). The resident had mood indicators of little interest in doing things, feeling down depressed, trouble sleeping, and feeling tired during the assessment period. The MDS revealed the resident was free from behavior	F 225		

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indicators. The resident required set up assist with bed mobility, transfers, dressing, personal hygiene and bathing.

Review of resident #1's cognitive CAA (care area assessment) dated 4/30/13 revealed the resident was very flighty in conversations and quickly went from one subject to another.

Review of the resident's ADL (activities of daily) CAA dated 4/30/13 revealed the resident had some need for assistance with care.

Review of the resident's psychosocial well-being CAA dated 4/30/13 revealed the resident was very busy talking to everyone and did not express interest in much.

Review of the resident's mood CAA dated 4/30/13 revealed the resident stated he/she is not happy right now, at times feels that staff has made untrue statement about him/her.

Review of resident #1's care plan revealed the facility failed to develop a temporary plan of care that addressed the resident's care needs upon admission to the facility on 4/23/13.

Review of the Nurses notes dated 4/27/13 at 10:30 p.m. revealed the resident reported to the facility charge nurse that he/she had talked to a facility staff member and had felt threatened since that conversation. The resident requested the Ombudsman's phone number and was shown where the Ombudsman's phone number was posted by the nurse's station. The resident gave no details of what had upset him/her.

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Review of the facility's alleged abuse, neglect and exploitation investigation revealed resident #1 had hand written a letter to Administrative staff A. The letter revealed the resident was afraid of a facility staff member and stated "I didn't come here to feel threatened or feel like I was in harm's way and I feel that way now." The resident expressed in the letter the staff member in question had told other staff untrue things about him/her. Further review of the letter revealed the resident had felt threatened since the second day of his/her stay in the facility. The resident stated "help me I'm afraid" in the letter written to Administrative staff A.

On 5-7-13 at 11:03 a.m. observation revealed the resident sat in his/her room quietly no mood or behavior indicators noted.

On 4/27/13 at 10:00 a.m. an interview with Administrative staff A revealed the resident had written a letter to him/her and the letter revealed the resident felt threatened by a facility staff member. Staff A revealed the resident had a long history of psychological issues and a diagnosis of a traumatic brain injury. Staff A revealed the resident was mad because the staff member in question refused to tolerate his/her {explicit word}. The staff member had worked with the resident in another facility and knew how to handle his/her behavior and would not tolerate the behavior in this facility. Staff A revealed an investigation was completed by him/her and determined not to be abuse and was not reported to the state mandated agency. Further interview with Administrative staff A revealed when a report of abuse, neglect or exploitation was received it was facility policy to report the incident to the

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F 225	Continued From page 9 appropriate state agency within 24 hours and complete a full investigation. Staff A revealed the facility had not gathered statements from staff members that had worked with the resident during the time of the alleged incident, had not taken statements from other residents concerning their treatment by the staff member in question, and had not suspended the alleged perpetrator. Staff A revealed the facility had collected a statement from the alleged perpetrator and determined the resident was having behavioral indicators and no abuse had occurred. On 5/7/13 at 3:38 p.m. Administrative staff A confirmed the facility failed to follow the Abuse, Neglect and Exploitation policy and complete a thorough investigation. Administrator staff A confirmed the facility failed to report the allegation of abuse to the state mandated agency. Review of the facility's Abuse, Neglect, and Exploitation policy dated 8/31/12 upon receiving a report of abuse, neglect and exploitation, the charge nurse will immediately report to the Administrator and/or DON (director of nurses), the alleged abuse will be reported to the appropriate state agencies within 24 hours, and employees of the facility accused of resident abuse will be suspended with or without pay until the Administrator reviewed the results of the investigation. The facility failed to follow the policy for Abuse, Neglect and Exploitation and failed to thoroughly investigate and report suspected abuse to the state mandated agency.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 28 with 3 residents included in the sample. Based on observation, interview and record review the facility failed to ensure the dignity for 1 of 3 sampled residents. (#2)

Findings included:

- Review of resident #2's significant change MDS (minimum data set) dated 4/17/13 revealed the resident had short and long term memory loss with severely impaired decision making abilities. The resident required extensive assist of one staff member for dressing, eating, and personal hygiene. The resident required extensive assistance of two staff for bed mobility, transfers, and walking,

Review resident #2's cognitive CAA (care area assessment) dated 4/18/13 revealed the resident had increased confusion and mental status decline. The resident had poor understanding of his/her abilities and safety.

Review of resident #2's care plan dated 11/21/12 revealed the resident required extensive assistance of staff for ADLs (activities of daily living). The care plan directed the staff to allow the resident sufficient time to complete his/her

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ADLs (activities of daily living) with as little hands on assistance as possible, ensure personal hygiene and oral care products are set up and prepared, the resident usually dressed him/herself completely. Provide the resident with as much privacy as possible when changing my clothes I am a very modest person.

On 5-7-13 at 10:30 a.m. observation revealed the resident sat on the edge of the bed. The resident wore a T-shirt, an incontinence brief and a pair of socks. The resident's hair was uncombed and the resident had unshaven facial hair. The resident's room door was open and the resident was visible from the hall.

On 5-8-13 at 1:04 p.m. the resident laid in bed on his/her right side. The resident's T-shirt was pulled up and exposed a large portion of the resident's bare back and part of the resident brief used to manage incontinence. The resident's room door was open and the resident was visible from the hall.

On 5-7-13 at 10:35 a.m. an interview with Licensed staff B revealed the resident was totally dependant on staff for all ADLs and had poor decision making abilities related to dementia. Staff B revealed the staff were expected to ensure the resident was dressed or covered with a blanket to maintain his/her dignity. The direct care staff were expected to shave the resident's facial hair and comb the residents hair with morning care and as often as needed. Staff B confirmed the resident was uncovered only wearing a T-shirt, a brief and was visible from the hall when he/she entered the room.

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F 241	Continued From page 12 The facility was unable to provide a policy in regards to resident dignity as requested on 5/9/13. The facility failed to provide care that ensured and maintained the resident's dignity.	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: The facility census totaled 28 residents with 3 residents included in the sample. Based on observation, interview and record review the facility failed to develop a temporary care plan for 1 of 3 residents. (#1) Findings included: - Review of resident #1's admission MDS (minimum data set) dated 4/30/13 revealed a BIMS (brief interview for mental status) score of 15 (cognitively intact). The resident had mood indicators of little interest in doing things, feeling down depressed, trouble sleeping, and feeling tired during the assessment period. The MDS revealed the resident was free from behavior indicators. The resident required set up assist with bed mobility, transfers, dressing, personal hygiene and bathing. Review of resident #1's cognitive CAA (care area assessment) dated 4/30/13 revealed the resident was very flighty in conversations and quickly went	F 281		

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from one subject to another.

Review of the resident's ADL (activities of daily) CAA dated 4/30/13 revealed the resident had some need for assistance with care.

Review of the resident's psychosocial well being CAA dated 4/30/13 revealed the resident was very busy talking to everyone and did not express interest in much.

Review of the resident's mood CAA dated 4/30/13 revealed the resident stated he/she was not happy at the time, and at times felt that staff had made untrue statements about him/her.

Review of resident #1's care plan revealed the facility failed to develop a temporary plan of care that addressed the resident's care needs upon admission to the facility on 4/23/13.

On 5-7-13 at 11:03 a.m. observation revealed the resident sat in his/her room quietly no mood or behavior indicators noted.

On 5-8-13 at 9:03 a.m. an interview with Administrative nurse D revealed staff D confirmed the facility failed to develop a temporary care plan for the resident. Staff D believed the MAR (medication administration record) and TAR (Treatment administration record) was the temporary care plan until the comprehensive care plan was developed.

The facility was unable to provide a policy in regards to development of termporary care plans as requested on 5/9/13.

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F 281	Continued From page 14 The facility failed to develop a temporary plan of care for the resident upon admission.	F 281		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility census was 28 residents. Based on the number and nature of the quality deficiencies cited during the complaint survey that completed on 5/14/13, the facility administration failed to manage the facility in a manner to meet the needs of all residents. Findings included: - The facility administration failed to manage the facility in a manner to meet the needs of the residents, as evidenced by this complaint survey including: a). Refer to F159. The facility census was 28 residents with 22 residents reviewed for management of personal funds. Based on observation, interview and record review the facility failed to have a system that utilized acceptable and accurate principles of accounting for 22 residents with a personal funds account including private pay residents with overdrawn account balances pooled with the funds of Medicaid-funded residents. Furthermore, the	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E630	A. BUILDING _____ B. WING _____	C 05/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANTHONY COMMUNITY CARE CENTER	212 N 5TH AVE ANTHONY, KS 67003

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F 490	Continued From page 15	F 490		

facility failed to have a system that included providing quarterly statements to the residents with a resident trust account and failed to have a system that maintained an accurate accounting of the resident trust account.

b). Refer to F160. The facility census totaled 28 residents with 10 reviewed for conveyance of personal funds. Based on interview and record review the facility failed to convey the funds of 2 of 10 sampled residents within 30 days of the resident's death. The facility failed to convey the balance resident #11, #12's trust account within 30 days of the residents death.

c). Refer to F225. The facility census totaled 28 residents. Based on observation, interview and record review, the facility failed to thoroughly investigate and report alleged abuse to the state mandated agency for 1 of 3 sampled residents. Resident #1 report an allegation of abuse/neglect by a member of the facility staff member. The facility failed to follow the policy for Abuse, Neglect and Exploitation and failed to protect the residents from the alleged perpetrator during the investigation and failed thoroughly investigate and report suspected abuse to the state mandated agency.

d). Refer to F241. The facility census totaled 28 with 3 residents included in the sample. Based on observation, interview and record review the facility failed to ensure the dignity for 1 of 3 sampled residents. Resident #2 was observed as he/she sat on the edge of the bed uncovered in an incontinence brief and a T-shirt from the hall. Further more the facility failed to provide care that maintained the resident's dignity.

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F 490	Continued From page 16 e). Refer to F281. The facility census totaled 28 residents with 3 residents included in the sample. Based on observation, interview and record review the facility failed to develop a temporary care plan for 1 of 3 residents. Resident #1 was admitted to the facility on 4/23/13 and 5/9/13 the facility failed to develop a temporary plan of care to direct the staff to the resident's care needs. f). Refer to KSA 26-41-102 d. The facility census totaled 28 residents. Based on record review and interview the facility failed to implement their written policy for prohibiting mistreatment, neglect and abuse of residents and misappropriation of resident property by not checking potential employees for personal and professional references for 4 of 5 sampled new employees. The direct care staff without references had access to all facility residents. The facility lacked an effective administration that managed resident trust funds, allegations of abuse, screening of potential new hires, dignified delivery of care, and the development of care plans for new residents.	F 490		